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# Doctor-Patient Confidentiality Versus Duty to Warn in the Context of AIDS Patients and Their Partners

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## Comment

### DOCTOR-PATIENT CONFIDENTIALITY VERSUS DUTY TO WARN IN THE CONTEXT OF AIDS PATIENTS AND THEIR PARTNERS

Imagine the following situation:

You are a general practitioner in a relatively large metropolitan city. You have been Bob's personal physician for years. During his recent annual physical examination, Bob asked that you test him for Acquired Immune Deficiency Syndrome (AIDS). Both the ELISA<sup>1</sup> and Western Blot<sup>2</sup> tests returned positive for the AIDS antibody. Although you have specifically advised him to do so, Bob has refused to discuss the test results with anyone—including his fiancée, his ex-wife, and any of his past sexual partners. You know his ex-wife personally as she is also one of your patients. You have not, however, met Bob's fiancée and have no information concerning his past sexual partners. Bob has prohibited you from discussing his condition with anyone.

This simple factual scenario presents a multitude of ethical, medical, and legal dilemmas. As the doctor, you find yourself in a precarious position, forced to choose between conflicting yet compelling courses of conduct. If you choose to tell Bob's contacts, you necessarily breach the traditional doctor-patient confidentiality, mandated by both the medical profession and the law.<sup>3</sup> If you re-

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1. See *infra* text accompanying notes 25-26.

2. See *infra* text accompanying note 27.

3. The Hippocratic Oath states in relevant part: "Whatsoever things I see or hear concerning the life of man, in attendance on the sick or even apart therefrom which ought not to be noised about, I will keep silent thereon, counting such things to be personal secrets." As quoted in J. WALTZ & F. INBAU, *MEDICAL JURISPRUDENCE* 234 (1971). For a more modern, yet limited, interpretation, see also AM. MEDICAL ASS'N, *PRINCIPLES OF MEDICAL ETHICS*.

The State of Maryland has enacted a specific statute that deals with confidentiality and medical records. MD. HEALTH-GEN. CODE ANN. § 4-301 (Supp. 1987) states:

(a) *Authorized disclosures*.—Any provider of medical care who has custody of medical records may reveal specific medical information contained in those records:

(1) To the individual on whom the records is kept or the individual's agent or representative; or

(2) As authorized in Article 48A, Subtitle 20 of the Code.

(b) *Prohibited disclosures*.—Any provider of medical care who has custody of medical records may not reveal specific medical information contained in those

spect the confidence, you may knowingly subject others to a foreseeable danger which ultimately may result in death.<sup>4</sup> Which path should you choose, and what will be the legal ramifications of your decision? Should the fact that the medical condition involved is AIDS play any special role in the decision? Does current Maryland

records to any person unless authorized by the individual on whom the record is kept.

(c) *Inapplicability of section.*—Subsection (b) of this section does not apply to a provider of medical care who has custody of medical records if the provider is:

- (1) Performing medical services or allied support services for or on behalf of a patient;
- (2) Providing information requested by or to further the purpose of a medical review committee, accreditation board, or commission, or in response to legal process;
- (3) Providing information required to conduct the proper activities of the health care provider;
- (4) Providing information to a government agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress;
- (5) Providing information at the request of a researcher for medical and health care research under a protocol approved by an institutional review board;
- (6) Revealing the contents of medical records under circumstances where the identity of the patient is not disclosed to the recipient of the records;
- (7) Providing information to an insurance company or to a defendant or the defendant's legal counsel, in connection with a potential or actual malpractice claim against a provider of medical care;
- (8) Providing information requested by another provider of medical care for the sole purpose of treating the individual on whom the record is kept;
- (9) Providing information to a third party payor for billing purposes only;
- (10) Providing information to a nonprofit health service plan or a Blue Cross or Blue Shield Plan to coordinate benefit payments under more than one sickness and accident, dental, or hospital and medical insurance policy other than an individual policy; or
- (11) Providing information to organ and tissue procurement personnel under the restrictions of § 5-408 of this article at the request of a physician for a patient whose organs and tissues may be donated for the purpose of evaluating the patient for possible organ and tissue donation.

(d) *Penalty.*—A provider of medical care who knowingly violates any provision of this section shall be liable to a plaintiff for any damages recoverable in law or equity, including reasonable attorney's fees.

4. Doctors "may be sued by patients for wrongful disclosure and personal suffering that might result from . . . disclosure if they breach confidentiality; they may also be sued by their patient's sexual partners if they knowingly fail to protect them from preventable harm or risk of infection from their patient's illness." Winston, *AIDS and a Duty to Protect*, 17 HASTINGS CENTER REP. 22 (1987). See also Lewis, *Duty to Warn Versus Duty to Maintain Confidentiality: Conflicting Demands on Mental Health Professionals*, 20 SUFFOLK U.L. REV. 579, 595 (1986) ("Courts have entertained suits for wrongful disclosure upon theories of invasion of privacy, express or implied statutory violations, breach of implied contract, and tortious violation of a duty to maintain confidentiality.").

law provide adequate guidance for doctors facing this very difficult situation?

### I. MEDICAL BACKGROUND

AIDS is both a frightening and a mysterious disease. Although progress has been made in researching its origins and effects, the alarming truth remains that once AIDS is contracted the result is invariably the same—death. There is no cure.<sup>5</sup> In fact, the lapse of time between diagnosis and death is approximately one and one-half years.<sup>6</sup> To date, 62,200 cases of AIDS have been reported in the United States.<sup>7</sup> In addition, experts predict that at least that many people suffer from AIDS-Related Complex (ARC). As of May 16, 1988, there had been 59,051 reported deaths resulting from AIDS.<sup>8</sup>

Although much is currently unknown about this fatal disease, the medical profession has made some limited determinations. AIDS "is a virus-caused condition which compromises the natural disease-resisting systems of its victims, thus rendering them extremely susceptible to infections."<sup>9</sup> It "is a profound irreversible immune dysfunction that is caused when the HIV [human immunodeficiency virus] infects the T4 lymphocytes, or special white blood cells . . . . As the body's immune system is impaired, opportunistic infections and/or rare malignancies continue to weaken the body until death occurs."<sup>10</sup>

Scientists further have determined that although deadly, the virus is not hardy. It is killed easily and cannot live outside the body for long periods of time.<sup>11</sup> In addition the HIV infection is difficult to contract and cannot be transmitted by casual contact.<sup>12</sup> The virus is transmitted through intimate sexual contact, parenteral exposure

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5. GOVERNOR'S TASK FORCE, AIDS AND MARYLAND 4 (1986). See also Curran, Clark & Gostin, *AIDS: Legal and Policy Implications of the Application of Traditional Disease Control Measures*, 15 LAW, MED. & HEALTH CARE 27 (1987).

6. Address by Edward N. Brandt, Jr., Chairman of Governor's Task Force on AIDS, Law & Medicine Class, University of Maryland School of Law (Oct. 28, 1987) [hereinafter Brandt Address].

7. Telephone inquiry to Surveillance & Evaluation Branch, United States AIDS Program, Center for Infectious Diseases, Centers for Disease Control (May 18, 1988) (Tel. no. (404) 639-3534) [hereinafter CDC Telephone Inquiry].

8. *Id.*

9. SMITH, CONGRESSIONAL RESEARCH SERVICE, AIDS: AN OVERVIEW OF ISSUES 2 (Sept. 8, 1987).

10. GOVERNOR'S TASK FORCE, *supra* note 5, at 4.

11. Brandt Address, *supra* note 6.

12. GOVERNOR'S TASK FORCE, *supra* note 5, at 2.

to infected blood or blood products, or perinatally from mother to fetus.<sup>13</sup> More specifically, with regard to sexual intercourse, "[a]lthough the AIDS virus is found in several body fluids, a person acquires the virus during sexual contact with an infected person's blood or semen and possibly vaginal secretions."<sup>14</sup>

Small . . . tears in the surface lining of the vagina or rectum may occur during insertion of the penis, fingers, or other objects, thus opening an avenue for entrance of the virus directly into the blood stream; therefore, the AIDS virus can be passed from penis to rectum and vagina and vice versa without a visible tear in the tissue or the presence of blood.<sup>15</sup>

The majority of AIDS cases involve homosexual males. Of the 62,200 AIDS cases reported as of May 16, 1988, 38,736 were homosexual or bisexual males; 4539 of those also had a history of intravenous drug abuse.<sup>16</sup> While those most at risk are homosexuals and intravenous drug users, cases among heterosexuals are increasing. Heterosexuals who abuse intravenous drugs are obviously at greater risk than those who do not.<sup>17</sup> This is not to say, however, that heterosexuals, even those who do not engage in illicit use of intravenous drugs, are free from danger.

The problem of AIDS in women presents special concerns. AIDS is spreading, and although "AIDS and HIV infection currently remain a predominantly male disease, the number of HIV infected women continues to grow . . . . [A]s [the] absolute number of women with HIV infection increases, so do the chances for producing HIV infected babies through the perinatal transmission of the virus."<sup>18</sup> In addition, "it may be difficult for women to identify themselves as being at risk for HIV infection because they may be unaware of the sexual or drug using behaviors of their past or present partners. As a result, women may be less likely to take knowing

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13. *Id.* See also U.S. DEP'T OF HEALTH & HUMAN SERVS., FACTS ABOUT AIDS 1 (Aug. 1985) [hereinafter FACTS ABOUT AIDS].

14. U.S. DEP'T OF HEALTH & HUMAN SERVS., SURGEON GENERAL'S REPORT ON ACQUIRED IMMUNE DEFICIENCY SYNDROME 16 (1987).

15. *Id.*

16. CDC Telephone Inquiry, *supra* note 7.

17. As of May 16, 1988, there was a total of 11,357 reported AIDS cases among intravenous drug users, of whom 8847 were male and 2511 were female. Of the male total, 4539 were homosexual or bisexual. *Id.*

18. GOVERNOR'S TASK FORCE, *supra* note 5, at 10.

precautions to protect themselves.”<sup>19</sup> Simply put, “[t]he greater the number of sexual partners, the greater the risk. The chances of infection from one encounter are between 1 in 1,000 and 1 in 10.”<sup>20</sup> Others say the risk of infection from a single sexual contact is approximately 1 in 300.<sup>21</sup> Of those infected, presumably not everyone will develop AIDS. In 1986 experts estimated that ten to forty percent of HIV-infected persons would progress to AIDS within five years of being infected.<sup>22</sup> Those same experts now fear that the rate is closer to 100 percent.<sup>23</sup>

It is important to note that existing “tests merely record the presence of *antibodies* to the HIV—the test does not confirm the presence of the virus itself.”<sup>24</sup> The two available tests are the ELISA and the Western Blot. The ELISA is basically a screening test. Its primary purpose is to detect negative results. A major drawback of the test is that it “is known to produce a high level of false positive results, which increases if the test is performed on non-high risk groups.”<sup>25</sup> Indications are that the ELISA test produces twenty to thirty percent false positives.<sup>26</sup> The more expensive Western Blot is a confirmatory test. It has an extremely low error rate, estimated to be approximately 0.5 percent. The accepted medical procedure is to first administer an ELISA. Should the test be positive, a second ELISA is performed. It is only if these first two tests are positive that a Western Blot is administered.<sup>27</sup> Even if a patient tests positive for the AIDS antibody, it is possible, although unlikely, that he or she may never actually develop the disease.<sup>28</sup> Seropositive individuals, however, are presumed capable of transmitting the infection to others.<sup>29</sup>

Returning to the hypothetical situation proposed earlier, Bob therefore must be considered capable of transmitting the AIDS vi-

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19. *Id.* Women now account for approximately 8% of all reported AIDS cases. The national average is expected to reach 11% in the near future. *Id.* at 9-10.

20. McAuliffe, *AIDS: At the Dawn of Fear*, U.S. NEWS & WORLD REPORT 60, 66 (Jan. 12, 1987).

21. Brandt Address, *supra* note 6.

22. GOVERNOR'S TASK FORCE, *supra* note 5, at 2.

23. Brandt Address, *supra* note 6.

24. GOVERNOR'S TASK FORCE, *supra* note 5, at 20. See also Aaronson, *The Medical-Legal Faces of AIDS*, MEDICAL MALPRACTICE PREVENTION 40, (Sept./Oct. 1987).

25. Hermann, *Liability Related to Diagnosis and Transmission of AIDS*, 15 LAW, MED. & HEALTH CARE 36, 37 (1987).

26. Brandt Address, *supra* note 6.

27. *Id.*

28. See *supra* text accompanying notes 22-23.

29. Curran, Clark & Gostin, *supra* note 5, at 27, 29.

rus. Even though he may not show signs of suffering from the disease, anyone who has had intimate sexual contact with him since his infection is at risk. The extent of the risk is, at this time, only speculative, but as previously mentioned, it may range anywhere from 1 in 10 to 1 in 1000.<sup>30</sup> Does the doctor have a duty to warn those at risk? If so, who should be warned? When should they be warned? What should they be told?

## II. LEGAL DUTY TO WARN

An individual has no common-law duty to warn innocent others of the existence of danger unless that individual is responsible for the creation of the danger. As was made abundantly clear by the Maryland Court of Appeals in *Pope v. State*,<sup>31</sup> "[u]nder the present state of our law, a person has no legal obligation to care for or look after the welfare of a stranger, adult or child."<sup>32</sup> The court went on to explain that: "Generally, one has no legal duty to aid another in peril, even when that aid can be rendered without danger or inconvenience to himself . . . . A moral duty to take affirmative action is not enough to enforce a legal duty to do so."<sup>33</sup> Suffice it to say that ordinarily "a person may stand by with impunity and watch another being murdered, raped, robbed, assaulted or otherwise unlawfully harmed."<sup>34</sup>

There are, however, exceptions to the common-law rule that no duty exists. "[W]hen the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability . . . if the defendant bears some special relationship to the dangerous person or to the potential victim."<sup>35</sup> In *Lamb v. Hopkins*<sup>36</sup> the State of Maryland expressly adopted the special relationship exception set forth in the *Restatement (Second) of Torts* section 315.<sup>37</sup>

In the hypothetical situation presented, Bob's fiancée, ex-wife

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30. See *supra* text accompanying notes 20-21.

31. 284 Md. 309, 396 A.2d 1054 (1979) (third party stood by while three-month-old infant was fatally beaten by his mother).

32. *Id.* at 324, 396 A.2d at 1064.

33. *Id.* (quoting W. LaFAVE & A. SCOTT, CRIMINAL LAW 183 (1972)).

34. *Id.*

35. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 435, 551 P.2d 334, 342-43, 131 Cal. Rptr. 14, 22-23 (1976).

36. 303 Md. 236, 492 A.2d 1297 (1985).

37. Section 315 carves out a limited exception to § 314's mandate that the "fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action." RESTATEMENT (SECOND) OF TORTS § 314 (1965). Section 315 states:

and other sexual partners are all presumably at risk. The question remains whether the section 315 exception, adopted in *Lamb*, applies to Bob's situation. In order to invoke the exception a special relationship must exist either (1) between the doctor and Bob which imposes a duty upon the doctor to control Bob's conduct, or (2) between the doctor and potential victim which gives the victim a right to protection. It seems clear that no special relationship exists between the doctor and either Bob's fiancée or past sexual partners. Bob's ex-wife, however, is a patient of the doctor, entitled to the same degree of care, counsel, and protection as Bob himself. She may well fall within the narrow confines of the exception.

Bob's own relationship with the doctor may be sufficient, on the other hand, to invoke the exception. Although Maryland has not spoken on the issue, some jurisdictions have held that the relationship between doctor and patient is sufficient to support the doctor's duty to exercise reasonable care to protect others against the dangers of the patient's illness.<sup>38</sup> The question is one of degree: Is their relationship such that it imposes a duty upon the doctor to control Bob's conduct? Section 319 of the *Restatement (Second) of Torts* attempts to answer this question.

Section 319 imposes a duty on those in charge of people having dangerous propensities. It specifically provides that: "one who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm."<sup>39</sup> The operative words contained in this section, "takes charge" and "control," are obviously vague. The *Restatement* has made no formal attempt to define them. Maryland has adopted a rather strict interpretation of the provision. In *Lamb* the court interpreted section 319 to mean that one typically takes charge of a third person by placing the individual in custody.<sup>40</sup> By way of illustration, the court went on to provide examples of situations in which "control" would exist. These included "a correctional institution incarcerating a dangerous criminal, or a mental

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There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless

(a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or

(b) a special relation exists between the actor and the other which gives to the other a right of protection.

38. See, e.g., *Tarasoff*, 17 Cal. 3d at 436, 551 P.2d at 344, 131 Cal. Rptr. at 24.

39. RESTATEMENT (SECOND) OF TORTS § 319 (1965).

40. *Lamb*, 303 Md. at 246, 492 A.2d at 1302.



institution confining a dangerous patient."<sup>41</sup> Although the examples were not in themselves exhaustive, they do suggest that at a minimum some curtailment of the third person's liberty is a prerequisite to a finding of sufficient "control."

If this strict construction of the *Restatement* is followed (no Maryland court has yet addressed the precise situation presented here), it seems assured that Bob's relationship with the doctor would not constitute "taking charge" or "control." This would change dramatically, however, should Bob's doctor in any way confine or restrict his freedom. The question then arises whether in-patient versus out-patient status is really a valid distinction at all.<sup>42</sup>

Even if the *Restatement's* "special relationship" exception is inapplicable in the present situation, the doctor still may have a duty to warn those at risk. Yet another exception to the general rule of no duty is one involving contagious diseases. The fact that Bob is infected with the AIDS virus may be a significant factor in determining whether the hypothetical situation falls within this particular exception.

"The trend in case law has been to place a duty on the doctors of patients with communicable diseases to warn the patients or their families that those in contact with such patients may contract the disease."<sup>43</sup> This exception is a logical, concrete extension of the belief that members of the medical profession owe a duty not only to their patients, but to all of society as well. Physicians have a responsibility to prevent the spread of contagious diseases by detecting and isolating them before large numbers of people become infected.<sup>44</sup> It is for this reason that "the courts hold that a doctor is liable to persons infected by his patient if he negligently fails to diagnose a contagious disease . . . , or, having diagnosed the illness, fails to warn members of the patient's family."<sup>45</sup> It generally is recognized that once a physician diagnoses a contagious disease it is the physician's duty to use reasonable care to advise members of the patient's immediate family of the existence of the disease and to

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41. *Id.* (citations omitted).

42. It is unclear how much "control" is required before § 319 will apply. Would nursing homes, halfway houses, and detention centers fall within the control section? Perhaps a distinction should be made between medical doctors and psychotherapists as "control" of the mind may continue after physical "control" has ceased.

43. Hermann, *supra* note 25, at 38.

44. *Report of the Council on Ethical and Judicial Affairs of the American Medical Association* 2 (Nov. 1987) [hereinafter *Council Report*].

45. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 436-37, 551 P.2d 334, 344, 131 Cal. Rptr. 14, 24 (1976).

warn them of its dangers.<sup>46</sup>

In *Wojcik v. Aluminum Company of America*<sup>47</sup> an employee brought suit against his employer for failing to disclose to him x-ray results showing that the plaintiff was developing tuberculosis. Wojcik's wife also filed suit alleging

that due to defendant's negligence, she came in close contact with her husband and lived with him in the same home as man and wife; that if defendant had advised her regarding her husband's true physical condition, the same would have been attended to and treated and immediate and proper steps would have been taken to avoid her contracting the disease; that early and prompt medical attention would have been received by her and that by reason of defendant's negligence she sustained serious, painful and probably permanent injuries . . . .<sup>48</sup>

The court found that the risk of Mrs. Wojcik "contracting tuberculosis from her husband, when unaware that he was so afflicted, was reasonably foreseeable by the defendant."<sup>49</sup> Furthermore, the court went on to say that:

It is the duty of a physician who is attending a patient afflicted with a contagious or infectious disease to exercise care in advising and warning members of the family and others who are liable to exposure of the existence and nature of the danger from the disease, to avoid doing any act which would tend to spread the infection, and to take all necessary precautionary measures to prevent its spread to other patients attended. A physician who fails to give such warning is negligent, and is liable in damages to any person injured as the direct and proximate result of his negligence.<sup>50</sup>

Is this, then, the end of the inquiry? Since AIDS is a contagious disease, does the doctor have a duty to inform all those at risk of contracting it?

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46. *Hofmann v. Blackmon*, 241 So. 2d 752, 753 (Fla. Dist. Ct. App. 1970).

47. 18 Misc. 2d 740, 183 N.Y.S.2d 351 (1959).

48. *Id.* at 745, 183 N.Y.S.2d at 357.

49. *Id.* at 746, 183 N.Y.S.2d at 357-58.

50. *Id.* at 746-47, 183 N.Y.S.2d at 358 (quoting 70 C.J.S. *Physicians and Surgeons* § 48 (1987)). See also *Davis v. Rodman*, 147 Ark. 385, 391-92, 227 S.W. 612, 614 (1921) ("[A]n attending physician is, in a certain sense, in custody of a patient afflicted with infectious or contagious disease. And he owes a duty to those who . . . are liable to be brought in contact with the patient, to instruct and advise them as to the character of the disease.").

AIDS is a disease like no other; it would be a mistake to include AIDS in the same category as other contagious diseases like smallpox, tuberculosis, typhoid, and scarlet fever. It is critically important to recognize that AIDS, unlike these other diseases, is not casually transmitted. Unlike typhoid and scarlet fever, AIDS does not pose a threat to everyone in close proximity to an infected person. Experts surmise that AIDS is difficult to contract.<sup>51</sup> Working with, speaking with, or even touching an AIDS victim does not place a person at risk. Studies have shown that those who live with AIDS-infected individuals do not become infected themselves. This fact alone requires that AIDS be considered separately from other communicable diseases.

Efforts to group AIDS with sexually transmitted diseases also must be avoided. Most venereal diseases are curable; AIDS is not. The common law may impose upon physicians the duty to inform an identifiable third party of an infectious disease.<sup>52</sup> Such a duty, however, should not be imposed in the case of AIDS for two reasons. First, to distinguish it from scarlet fever and similar diseases, AIDS is not—cannot be—transmitted through casual contact. Second, AIDS cannot be equated with other sexually transmitted diseases because, at least at present, there is no cure.<sup>53</sup> In effect, doctors would be telling people who already have been exposed to the virus that they have been so exposed, but that if they do succumb to the disease, no cure is available.

Although not specifically accepted or rejected in Maryland, there is conceivably one more argument to be made for advocating that the hypothetical doctor has a duty to warn Bob's contacts. This duty was first enunciated in the landmark case of *Tarasoff v. Regents of the University of California*.<sup>54</sup> In that case, Prosenjit Poddar killed Tatiana Tarasoff. The decedent's parents filed suit against Poddar's

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51. See *supra* note 12 and accompanying text.

52. See *supra* notes 48-51 and accompanying text.

53. The Code of Maryland Regulations (COMAR) provides for contact tracing when certain sexually transmitted diseases are reported. When a case of syphilis is reported, "[a]ll persons identified as having had potentially infective contact with a patient . . . receive medical and laboratory examination[s] and . . . receive medical treatment for syphilis on an epidemiologic basis." MD. REGS. CODE tit. X, § 10.06.01.18 (1983). If other venereal diseases are reported it is "the duty of the physician . . . to interview the patient immediately in order to ascertain the names, descriptions, and addresses of all persons with whom the patient has had potentially infective contact." *Id.* § 10.06.01.22. These names are then forwarded to a state health officer so that the at-risk individuals can be contacted. This procedure is not followed with cases of AIDS, presumably because it would discourage people from being tested.

54. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

therapist, claiming that Poddar had informed the therapist of his intent to kill an unnamed, readily identifiable woman. They claimed that the therapist had a duty to warn the intended victim or her family. Agreeing with the plaintiffs, the court held that "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."<sup>55</sup> The court did not specifically mandate that warnings be given. Rather, it recognized that discharge of the duty

may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.<sup>56</sup>

The court went on to say that the duty to do something arises upon balance of a number of considerations. These factors include: (1) the foreseeability of harm to the plaintiff (here, Bob's contacts); (2) the degree of certainty that the plaintiff suffered injury; (3) the closeness of the connection between the defendant's (doctor's) conduct and the injury suffered; (4) the moral blame attached to the defendant's conduct; (5) the policy of preventing future harm; (6) the extent of the burden on the defendant and consequences to the community of imposing a duty to exercise care with resulting liability for any breach; and (7) the availability of insurance.<sup>57</sup> Applying the above criteria to the *Tarasoff* facts, the court found that the therapist indeed might owe a duty to foreseeable victims.<sup>58</sup>

As previously mentioned, Maryland has neither accepted nor rejected the *Tarasoff* holding. Although it may choose to do so in the future, the court as yet has not been forced to make a decision.<sup>59</sup>

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55. *Id.* at 439, 551 P.2d at 345, 131 Cal. Rptr. at 25.

56. *Id.* at 431, 551 P.2d at 340, 131 Cal. Rptr. at 20.

57. *Id.* at 434, 551 P.2d at 342, 131 Cal. Rptr. at 22.

58. A later California decision interpreted the *Tarasoff* duty to warn to require a "known, identifiable victim." *Thompson v. County of Alameda*, 27 Cal. 3d 741, 758, 614 P.2d 728, 738, 167 Cal. Rptr. 70, 80 (1980).

59. Two Maryland cases, although factually dissimilar to *Tarasoff*, have cited the case. In *Shaw v. Glickman*, 45 Md. App. 718, 415 A.2d 625 (1980), the wife's lover was shot by her husband when he found them in bed together. The injured lover then brought suit against the husband's psychiatric team claiming that they had failed to warn him of the husband's unstable and violent condition. The court found no merit to the claim as "there was no threat revealed to the 'team' by [the husband] to kill or injure Dr. Shaw." *Id.* at 725, 415 A.2d at 630. Since Shaw was not a foreseeable victim, there was no duty

Initially, the question arises whether *Tarasoff*, which pertains to psychotherapists, can be extended to medical doctors as well.<sup>60</sup> Once this threshold is reached, the factors delineated in *Tarasoff* must be considered. Again, it is instructive to refer to the hypothetical situation presented earlier. It is entirely foreseeable that Bob's contacts will be endangered if the doctor chooses not to warn them of Bob's illness. The question is really one of practicality, identifiability, and reasonableness. The doctor knows Bob's ex-wife personally. In fact, as already discussed, her section 315 "special relationship" with the doctor probably entitles her to be warned. Bob's fiancée, although not personally known to the doctor, certainly falls within the ambit of *Tarasoff* foreseeability. She can be readily identified. She actually may present the strongest argument in favor of disclosure because she is the person most likely to have sexual contact with Bob in the future, and she may not yet have been infected with the virus. She is, therefore, one person who may still be saved. Presumably, the other contacts are no longer engaging in sexual intercourse with Bob; if they were going to get the disease from Bob, they already have contracted it. Warning them at this time may benefit the contacts' future sexual partners, and may influence their decisions regarding pregnancy, but it will do nothing to prevent these immediate contacts from developing AIDS as a result of their relations with Bob. It is clear that if the doctor fails to warn Bob's contacts, each *could* suffer some degree of harm.<sup>61</sup>

If any of these contacts develop AIDS, it will be certain that each has suffered some kind of injury. More difficult to determine, however, is the closeness of the connection between the doctor's failure to warn and the ultimate injury suffered by the AIDS victims.<sup>62</sup> This is equally true of all of Bob's contacts. Matters of proximate cause and proof become especially problematic. There is really no accurate method of determining from whom the infection

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to warn him. In *Furr v. Spring Grove State Hosp.*, 53 Md. App. 474, 454 A.2d 414 (1983), the parents of a young boy who was brutally murdered by a patient who left the hospital brought suit against, *inter alia*, the hospital. The court found that the defendants did not owe a duty to the young boy, stating that before a duty can exist "the victim must be readily identifiable." *Id.* at 489, 454 A.2d at 421.

60. The "degree of dependence and trust patients place on their therapist often exceeds the levels of reliance they ordinarily place on medical doctors." *Lewis, supra* note 4, at 595.

61. See *supra* notes 22-23 and accompanying text. In addition, these contacts, unaware of their at-risk status, may infect others or pass the disease along to their children.

62. See *Davis v. Rodman*, 147 Ark. 385, 227 S.W. 612 (1921) (demonstrating problems of proximate cause in suit against doctor for failing to warn family members of patient's typhoid condition).

is contracted. There is almost no way to prove that Bob's contacts contracted the virus from him. This is a particularly troublesome dilemma as it requires probing investigations into individuals' private lives. Perhaps Bob's ex-wife was not faithful during the marriage. Perhaps she had numerous encounters with intravenous drug users before their marriage. Maybe her present boyfriend is bisexual. The same may be true of Bob's other sexual partners. The long incubation period associated with AIDS<sup>63</sup> only serves to make the causation problem more difficult.

The fourth *Tarasoff* factor to be evaluated is the moral blame attached to the doctor's conduct—more specifically, the doctor's deliberate decision not to warn Bob's contacts. This is a difficult factor to assess. At first glance, a conscious decision not to warn of potential death strikes one as morally indefensible. On the other hand, it is really the AIDS carrier who has behaved intolerably. It is the patient, by refusing to disclose his or her medical condition to sexual partners, who creates this situation. The patient forces the doctor into the position of either breaking a confidence or failing to warn. Although jurors might not readily agree with a doctor's decision to remain silent, they probably would not condemn such conduct either.

Another factor of particular interest in the context of AIDS is the extent of the burden on the doctor and the consequences to the community of imposing a duty to exercise care with resulting liability for breach. If the doctor is required to warn potential third-party victims of an AIDS patient's condition, many experts are convinced that fewer people will come in for testing and treatment.<sup>64</sup> If true, this could have disastrous effects on efforts to research, understand, control, and cure AIDS. It is absolutely essential that statistics on AIDS be accurate and continually updated. The more that scientists know about the circumstances surrounding the disease, the better their chances of eventually developing a cure. In the long run, it would be more beneficial to society as a whole to minimize the deterrents to being tested. Furthermore, requiring doctors to warn potential victims would place a heavy burden on the doctors' shoulders. Would the hypothetical doctor have to investigate Bob's personal life? Would the doctor be required to track down all of the sexual partners that Bob has had during his lifetime? And what

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63. Medical experts approximate the incubation period to be anywhere between six months and five years or more. *FACTS ABOUT AIDS*, *supra* note 13, at 2.

64. GOVERNOR'S TASK FORCE, *supra* note 5, at 24. *See also* The Sun (Baltimore), July 1, 1988, at A1, col. 2.

would the doctor tell them, assuming, of course, that they could even be located?" Is it reasonable, practical, or efficient to require this of doctors?

The final two factors include the availability of insurance and the public policy of preventing future harm; only the latter merits discussion here.<sup>65</sup> On the one hand, requiring a warning actually might cause future harm. If at-risk individuals, concerned about confidentiality, avoid testing, then more people eventually could be subjected to the virus. On the other hand, warnings might influence the behavior of those warned, thereby potentially protecting their future sexual contacts, their future children, and society in general.

Even if Maryland were to adopt the *Tarasoff* rule and extend the delineated duty to medical doctors, it is difficult to say whether the proposed hypothetical AIDS scenario would require the doctor to warn potential victims. Does an AIDS patient pose "a serious danger of violence to others"? The answer is not as readily apparent as one might think. The threat is real and the result is death, but what are the actual chances of that happening? And how much of a chance is sufficient to constitute a "serious danger"? Initially it was thought that sexual partners of HIV-positive individuals had a 1 in 1000 chance of contracting the virus with each sexual encounter. Even if someone did contract the virus there was still only a ten to forty percent chance of developing AIDS.<sup>66</sup> These statistics are constantly changing. No one is really sure of the risks. Recent speculation includes a 1 in 300 chance of contracting the virus and a 100 percent chance of ultimately succumbing to AIDS. These statistics are critically important to the issue at hand. The greater the risk, the more convincing the argument for warnings. Also of import are the individual's sexual practices. If a condom always is used, the risk is reduced dramatically. The frequency with which the individual has sexual intercourse is also a relevant factor. Clearly the risks fluctuate with each individual case.

It is for these reasons that even if Maryland were to adopt a duty to warn, implementation would have to be on a case-by-case basis. At the very least, the potential victim would have to be readily identifiable.<sup>67</sup> And as previously mentioned,<sup>68</sup> it would be extremely difficult to establish proximate cause. It is important to re-

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65. Although the availability of insurance is of critical importance to AIDS victims, it is not particularly relevant here given the narrow focus of this Comment.

66. See *supra* note 22 and accompanying text.

67. See *supra* note 59.

68. See *supra* notes 62-63 and accompanying text.

member that the adequacy of the doctor's conduct "must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances."<sup>69</sup> It is well-settled law that

[t]hree basic elements are necessary to state a cause of action in negligence. First, the defendant must be under a duty to protect the plaintiff from injury. Second, the defendant must fail to discharge that duty. Third, the plaintiff must suffer actual loss or injury proximately resulting from that failure.<sup>70</sup>

Even if Maryland specifically adopts *Tarasoff*, and even if the doctor fails to warn a foreseeable victim, it still is doubtful that the physician actually would be held liable for the breach.<sup>71</sup>

### III. DOCTOR-PATIENT CONFIDENTIALITY

In the *Tarasoff* decision the court briefly addressed the issue of doctor-patient confidentiality. Defense counsel raised the argument that "the giving of a warning . . . constitutes a breach of trust which entails the revelation of confidential communications."<sup>72</sup> The court elected a balancing approach, stating that in limited situations public policy demands that the confidence be breached. The court noted that "the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others."<sup>73</sup> This is in harmony with the medical profession's own ethics which, as set forth in the *Principles of Medical Ethics* of the American Medical Association, provide in relevant part that "[a] physician may not reveal the confidence entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community."<sup>74</sup>

To a certain extent, it seems logical that a patient may expect confidentiality, but it is equally logical that this confidentiality have

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69. *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 439, 551 P.2d 334, 345, 131 Cal. Rptr. 14, 25 (1976) (citation omitted).

70. *Lamb v. Hopkins*, 303 Md. 236, 241, 492 A.2d 1297, 1300 (1985) (citations omitted).

71. Even the doctor who ultimately prevails in court will have been forced to litigate the issue, with possible damage to reputation and an increase in insurance premiums. The fact that the doctor ultimately may prevail is not a viable solution to the problem at hand.

72. *Tarasoff*, 17 Cal. 3d at 440, 551 P.2d at 346, 131 Cal. Rptr. at 26.

73. *Id.* at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27 (citation omitted).

74. AM. MEDICAL ASS'N, *supra* note 3.



limits. "It is not reasonable for a patient to expect a [doctor] to allow him to inflict serious harm on another person."<sup>75</sup> The *Tarasoff* court concluded "that the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins."<sup>76</sup>

Yet it must be noted that AIDS is a unique disease, perhaps demanding special consideration. The terrible social stigma associated with this deadly disease cannot be overlooked or overestimated. Fear of AIDS, coupled with and resulting from the current paucity of concrete information about the disease, has fueled a fire of panic. There are numerous reports of infected individuals losing their homes, jobs, friends, and insurance benefits.<sup>77</sup> The effects on the patient from a breach of confidentiality simply cannot be ignored.

Society also may suffer from such a breach. The public's confidence in the confidentiality of test results is of critical importance in encouraging individuals to be tested. Another relevant consideration is the fact that, as yet, there is no cure for AIDS. Little can be done for those afflicted. Since "[h]aving AIDS or HIV infection, or knowing that one has been exposed directly to the virus, can have severe psychological, social and economic consequences for an individual and his or her family,"<sup>78</sup> it may not be beneficial to breach a confidence and tell someone who would rather not know.

The State of Maryland deliberately chose not only to advocate but also to strengthen the medical profession's traditional policy regarding the importance of maintaining doctor-patient confidentiality.<sup>79</sup> Section 4-301 of the Health-General Article of the Maryland Annotated Code is entitled "Disclosure of Medical Records" and provides for both authorized and prohibited disclosures of information.<sup>80</sup> By enacting section 4-301(b), the legislature gave additional force to the mandate requiring that patient records be kept confidential. Subsection (b) states in full that "[a]ny provider of medical care who has custody of medical records may not reveal specific

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75. Greenberg, *The Dangerous Patient and Psychiatric Liability*, 2 TREATMENT TRENDS 2 (1987).

76. *Tarasoff*, 17 Cal. 3d at 442, 551 P.2d at 347, 131 Cal. Rptr. at 27.

77. GOVERNOR'S TASK FORCE, *supra* note 5, at 2.

78. *Id.*

79. See *supra* note 3.

80. MD. HEALTH-GEN. CODE ANN. § 4-301 (Supp. 1987).

medical information contained in those records to any person unless authorized by the individual on which the record is kept."<sup>81</sup>

It seems clear that should the hypothetical doctor be practicing in Maryland, and should the physician decide that the danger presented by Bob to his sexual partners is so great as to warrant a breach of confidentiality,<sup>82</sup> the State would make any such breach actionable. Maryland has provided for more strict adherence to the doctrine of confidentiality than has the medical profession itself. While the profession would allow disclosure if the doctor "is required to do so by law" or if "it becomes necessary in order to protect the welfare of the individual or the community," the Maryland statute provides no such exception. The doctor "may not reveal specific medical information . . . to any person unless authorized by the individual on whom the report is kept."<sup>83</sup> Regardless of a third person's relationship to the patient—whether it be that of spouse, other immediate family, or casual acquaintance—a doctor is prohibited from revealing medical information concerning the patient to the third person. Consequently, as long as Bob insists on confidentiality, the doctor is statutorily precluded from discussing Bob's condition with his ex-wife, fiancée, or any other potential sexual partner.

The penalty for any disclosure is potentially quite high. Subsection (d) of the statute delineates the penalty for any breach of confidentiality which falls within the provision. It specifies that "[a] provider of medical care who knowingly violates any provision of this section shall be liable to the plaintiff for any damages recoverable in law or equity, including reasonable attorney's fees."<sup>84</sup> In order to be subject to penalty, the doctor must knowingly violate the statute. This may or may not be a difficult requirement to meet as any decision regarding liability will necessarily turn on the definition of "knowingly." Is "knowingly" synonymous with "intentionally" or does it simply refer to knowledge of the law? Citizens, including doctors, are presumed to know the law. Certainly, it would be no

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81. *Id.* at (b).

82. See *supra* notes 73-77 and accompanying text.

83. MD. HEALTH-GEN. CODE ANN. § 4-301(b) (Supp. 1987) (emphasis added). In stark contrast to Maryland's confidentiality statute, the American Medical Association recently "urged physicians to warn the sexual partners of patients found to carry the AIDS virus if there was no other way to alert them to the danger." The association's 420-member House of Delegates concluded that "the physician has a responsibility to inform the spouse or known partners. This is more than an option. This is a professional responsibility." *The Sun* (Baltimore), July 1, 1988, at A1, col. 1.

84. MD. HEALTH-GEN. CODE ANN. § 4-301(d) (Supp. 1987).

defense for a doctor to say that he or she was not aware of the statute's existence.

Additionally, it is clear that the thrust of the statute is against disclosure. Nondisclosure is the rule, not the exception; unless the doctor's situation falls within a specific exception provided for in subsection (c) of the statute, the physician must not disclose the information. Therefore, the only real inquiry involves whether the doctor's particular circumstances are sufficient to place him or her within a subsection (c) exception.<sup>85</sup>

There are a host of exceptions to the apparent blanket prohibition against disclosure.<sup>86</sup> Of the eleven listed in subsection (c), none specifically addresses the problem posed in the earlier hypothetical situation. It is at least arguable, however, that section 4-301(c)(3) could be interpreted to include telling Bob's contacts if he refuses to do so. The exception, an extremely broad one, excludes "[p]roviding information required to conduct the proper activities of the health care provider."<sup>87</sup> "Proper activities" conceivably could include any number of things. Given the earlier discussion of doctors' duty to society as a whole,<sup>88</sup> warning Bob's sexual contacts may be "proper activities of the health care provider." Perhaps in such a situation, the doctor's duty to society supersedes the duty to Bob. If this is indeed the case, the doctor will not be liable for violation of section 4-301. The inquiry again will focus on the limited breach of confidentiality exception espoused by the medical community.<sup>89</sup>

Even if a situation does not fall clearly within one of the enumerated exceptions, the statute leaves room for a clever doctor (or the doctor's attorney) to maneuver a bit. Subsection (b) says that a health care provider "who has custody of medical records may not reveal specific medical information contained in those records."<sup>90</sup> If read literally, the statute says that the health care provider who has *custody* of the records may not reveal *specific* information *contained* in

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85. There is, of course, also the question regarding the amount of the plaintiff's damages.

86. MD. HEALTH-GEN. CODE ANN. § 4-301(c) (Supp. 1987). For the full text of these exceptions, see *supra* note 3.

87. MD. HEALTH-GEN. CODE ANN. § 4-301(c)(3) (Supp. 1987).

88. See *supra* text accompanying notes 44-46.

89. It also is noteworthy that a second exception contained in § 4-301(c)(4) establishes exclusion for "[p]roviding information to a government agency performing its lawful duties as authorized by an act of the Maryland General Assembly or the United States Congress." MD. HEALTH-GEN. CODE ANN. § 4-301(c)(4) (Supp. 1987). In situations in which disclosure is required by law, the statute obviously is not violated.

90. *Id.* § 4-301(b).

the records. Certain questions immediately come to mind: must the doctor actually have custody of the records? In addition, what is meant by specific? Could the hypothetical doctor, without mentioning AIDS, simply tell Bob's contacts that Bob is ill? Could the doctor go so far as to say that Bob is ill and then recommend "safe sex"? And what about information not contained in the records? Will failure to adequately document effectively release the doctor from any confidentiality requirement? Until these questions are answered, the full reach and intent of the statute will remain unclear. As previously mentioned, should it be decided that section 4-301<sup>91</sup> does not prohibit disclosure in situations similar to the proposed hypothetical, the statute would not be violated and the inquiry again could focus on the traditional confidentiality doctrine.<sup>92</sup>

#### IV. MARYLAND TASK FORCE RECOMMENDATIONS

Although it did not deal specifically with the problem of doctor-patient confidentiality and duty to warn, the Governor's Task Force on Acquired Immune Deficiency Syndrome<sup>93</sup> addressed a number of issues pertaining to AIDS. The Task Force's subsequent recommendations to the Governor are at least tangentially related to the issue at hand and will be discussed briefly here.

The Task Force does not recommend any further legislation in this area. Rather, it insists that emphasis should be placed on education.<sup>94</sup> Since there is presently no cure for the disease, the Task Force advocates focusing on prevention. It believes that "education is key to preventing the spread of AIDS and HIV infection before it reaches an even greater number of Marylanders. No matter who is the audience, the general message remains the same."<sup>95</sup> The Task Force urges individuals to adopt behaviors which will help prevent transmitting the disease, to know their sexual partners (their background, history, and possible risk of HIV infection), and to learn the facts about the disease.<sup>96</sup> Education is indeed important and necessary, but it might not be enough. Some individuals, presumably not unlike Bob's ex-wife or fiancée, are not aware of their at-risk status.

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91. *Id.* § 4-301.

92. *See supra* text accompanying notes 73-77.

93. "In December 1985, Governor Harry Hughes appointed a Task Force composed of twenty-two Maryland citizens . . . . The Task Force was asked to advise the Executive Branch and help develop statewide policies" concerning AIDS. GOVERNOR'S TASK FORCE, *supra* note 5, at v (preface).

94. *Id.* at 44.

95. *Id.*

96. *Id.*

A woman may know the facts about AIDS, but have no idea that her husband of twenty-seven years is bisexual. She, therefore, will not make a concerted effort to protect herself from contracting the disease.

In addition, the Task Force strongly advises *against* any legislation regarding mandatory reporting or contact tracing.<sup>97</sup> While it believes that confirmed cases of AIDS should continue to be reported, the Task Force is adamantly opposed to adopting legislation or amending regulations to include reporting of HIV-positive individuals.<sup>98</sup> As an initial matter, the Task Force believes that the Secretary of the Department of Health and Mental Hygiene "can require the reporting by physicians . . . , under the Annotated Code of Maryland, Health General Articles (H.G.) § 18-201 . . . , of individuals who have certain infectious or contagious diseases."<sup>99</sup> Section 18-201 states in relevant part that "[a] physician with reason to suspect that a patient under the physician's care has an *infectious or contagious disease* that endangers public health shall submit immediately a report to the health officer for the county where the physician cares for that patient."<sup>100</sup>

A list of the reportable infectious or contagious diseases is contained in the Code of Maryland Regulations.<sup>101</sup> At this time, only *confirmed* cases of AIDS are reportable.<sup>102</sup> It is the position of the Task Force that positive HIV test results should not be reported at all, but that in the event an amendment regarding reporting of HIV-positive individuals is warranted, the Secretary of the Department of Health and Mental Hygiene has ample authority to effectuate the change.<sup>103</sup> The Task Force is concerned that mandatory reporting of HIV infection would discourage individuals from being tested.<sup>104</sup> Although a valid concern, the question again arises as to what makes this disease different from those presently reportable.<sup>105</sup> One answer is that the test presently being administered is technically inaccurate. It does not confirm the presence of a disease; rather, it merely detects the presence of antibodies indicating exposure to the infection. In addition, the test produces a number of false

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97. *Id.* at 21.

98. *Id.*

99. *Id.*

100. MD. HEALTH-GEN. CODE ANN. § 18-201 (1987) (emphasis added).

101. MD. REGS. CODE tit. X, § 10.06.01.02 (1983).

102. *Id.* § 10.06.01.02A.(1)(b)(i).

103. GOVERNOR'S TASK FORCE, *supra* note 5, at 24.

104. *Id.*

105. See *supra* note 102 and accompanying text.

positives.<sup>106</sup>

Originally, these arguments against mandatory reporting may have been meritorious. It was thought that only ten to forty percent of seropositive individuals ultimately would develop AIDS.<sup>107</sup> On balance, it seemed fundamentally unfair to subject an individual to the fear, panic, and social stigma associated with AIDS when the chances of developing the disease were relatively small. Mandatory reporting would have stigmatized a number of perfectly healthy individuals who posed no threat to society.

These same arguments are less forceful today. Although an ELISA test does produce twenty to thirty percent false positives, two ELISAs and a confirmatory Western Blot reduce the chance of error to 0.5 percent.<sup>108</sup> As testing improves, the fear of subjecting perfectly healthy individuals to alienation and discrimination is less real. The problems of substantial over-inclusivity are dramatically reduced. Furthermore, medical experts now fear that the percentage of individuals who eventually progress from HIV positive to AIDS is close to 100 percent.<sup>109</sup> It also is important to remember that seropositive individuals are presumed capable of transmitting the disease, even if they show no signs of illness themselves.<sup>110</sup>

The real question is whether mandatory reporting of HIV-positive results will seriously discourage testing. Such an effect could prove disastrous to the individual, his or her contacts, and society as well. It is important to recognize that third parties are no *more* at risk if individuals are tested and results are not reported than they are if no test is ever administered. It is critical that individuals be

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106. See *supra* notes 24-26 and accompanying text.

107. See *supra* note 22 and accompanying text.

108. See *supra* note 27 and accompanying text.

109. See *supra* note 23 and accompanying text.

110. See *supra* note 29 and accompanying text. The appropriate test is really one of balancing interests, costs, and benefits. Although a seropositive individual definitely poses a potential threat to the community, the severity of that threat changes with each new set of circumstances. Since the virus is not casually transmitted, responsible individuals conceivably can monitor and modify their own behavior so as to virtually eliminate any danger to others. Perhaps the individual will no longer engage in sexual activities, or will engage in sex only with a condom. Others, however, will not act responsibly. See, e.g., *The Washington Post*, Nov. 22, 1987, at A1, col. 1. They will refuse to accept the test results, will deny the seriousness of their condition, and will continue to conduct their lives as they have in the past, taking no special precautions. There are still others who, angered by the unfairness of their predicament, will deliberately be promiscuous for the sole purpose of infecting others. It is not the seropositive individuals who pose the real threat to society, but rather individuals who test positive yet refuse to alter their behavior. Unfortunately, there is no way to distinguish between the two until it is too late.

tested. Once the results are known, these individuals may choose to modify their own behavior. They may, on their own initiative, tell sexual partners of their condition. If not, there is still a chance that further counseling will convince them to do so. If, however, fear of mandatory reporting prevents individuals from getting tested in the first place, nothing can be done to prevent them from engaging in high-risk behavior. Society as a whole benefits by encouraging testing and thereby reducing high-risk behavior. In addition, testing provides essential statistics that help researchers in their attempt to learn more about the disease and eventually find a cure.

The strength of the Task Force's decision to oppose mandatory reporting rests on its conclusion that individuals otherwise would never consent to testing. To the extent that this premise is correct, the decision is laudable. To the extent that the Task Force decision stems from concern regarding the accuracy of the test and the percentage of individuals who progress from HIV-positive status to AIDS, the reasoning is flawed. These factors simply do not outweigh the interests of innocent third parties and society in general.

This same belief that individuals will be deterred from seeking testing and proper medical care has prompted the Task Force to recommend "that active, contact tracing for AIDS and HIV infection be handled differently than it is for other sexually transmitted diseases."<sup>111</sup> There are a number of reasons for this determination. As an initial matter, the Task Force points out that "[a]ctive routine contact tracing for AIDS or HIV infection would be difficult to pursue effectively without strong legal safeguards against discrimination."<sup>112</sup> In addition, since there is as yet no cure available, the "negative psychological and social impact of being told one is a possible contact of an HIV-infected person may be as damaging as the risk of acquiring the disease itself."<sup>113</sup> The Task Force also mentions that "[e]ven if a third party is notified or seeks medical care, appropriate counseling and education are the primary services that can be offered to the contact."<sup>114</sup> The Task Force seems to be saying that since these are the only services available and since they can be readily obtained by any third party, contact tracing is unnecessary. This begs the question. Those who are completely unaware of their at-risk status will not seek help. When third-party contacts are

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111. GOVERNOR'S TASK FORCE, *supra* note 5, at 24. Health officials do engage in contact tracing when a venereal disease is involved. See *supra* note 53.

112. GOVERNOR'S TASK FORCE, *supra* note 5, at 24.

113. *Id.*

114. *Id.*

notified of their possible exposure, they are made aware of the potential dangers and can adjust their lifestyles accordingly.

Contact tracing also presents a number of practical problems. It is, by definition, voluntary. Infected individuals may choose not to reveal the names of their contacts. Even if names are indeed released, it may be difficult to verify that the contact actually occurred before the third party is notified of the possible exposure and any negative consequences occur.<sup>115</sup> It also would be extremely difficult to keep these lists confidential.

It seems that, at least to a certain extent, each of the above factors applies to other sexually transmitted diseases as well. Certainly the practical problems of confidentiality and verification of contacts are equally applicable to other diseases. Although perhaps not as severe as with AIDS or HIV infection, victims of sexually transmitted diseases suffer from a certain amount of social stigma. One major difference, however, is the fact that AIDS invariably results in death. Other sexually transmitted diseases at least can be controlled.

The Task Force is concerned primarily with facilitating the testing of at-risk individuals. Since contact tracing could seriously impede this objective, the Task Force recommends that the onus be on health care providers to "encourage HIV-infected patients to speak directly" with their sexual partners.<sup>116</sup> "Given the serious nature of HIV infection and the availability of properly trained counselors and providers, the Task Force believes that, in most cases, patients will cooperate with the provider's request."<sup>117</sup> This may or may not be a naive assumption. In any event, the Task Force has placed a heavy burden on the medical profession and has neglected to give health care providers adequate direction.

The Task Force advises doctors to encourage their patients to tell their sexual contacts of the infection, but goes on to admit that there "are instances . . . when these professionals may be *obligated* to notify persons *known* to have had significant exposures to HIV infection."<sup>118</sup> If "the health care provider encourages the HIV-infected patient to communicate to his/her sexual . . . contacts the need to be evaluated and such cooperation is explicitly refused," the Task Force believes that any *known* third parties should be notified.<sup>119</sup>

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115. *Id.*

116. *Id.* at 21.

117. *Id.* at 24.

118. *Id.* at 21.

119. *Id.* at 22. By "notify," the Task Force envisions a semi-anonymous warning. The



Just such a situation is presented in the hypothetical. Bob has refused to discuss his condition with anyone. According to the Task Force, the doctor would not only be justified but may be obligated to inform any known contacts. Although the doctor would not be expected to discern the names and whereabouts of Bob's sexual contacts, the physician no doubt would have to warn both Bob's ex-wife and his fiancée.

The Task Force only requires that the doctor notify those sexual contacts known to him or her. The doctor is under no duty to investigate or interrogate a patient. Still, the entire procedure seems to undermine the doctor-patient relationship. It encourages the patient to lie. When asked if the patient's sexual contacts have been told of the infection, it would save both doctor and patient a lot of trouble if the patient simply says "yes." Unless the doctor has a duty to follow up on this information, unless the doctor calls those known sexual contacts and asks if they have really been told, the inquiry will end when the patient says "yes." Does the doctor really satisfy the duty to warn by asking the patient? If not, what more must the doctor do?

The Task Force believes that in situations similar to the proposed hypothetical "the duty to notify is a matter of good medical practice and supersedes the need to maintain confidentiality."<sup>120</sup> It neglects to address, however, the impact of Maryland's disclosure statute or the ramifications that such conduct could have for the doctor.

## V. CONCLUSION

Although the Task Force did address a number of important issues concerning AIDS, it did not provide any clear answers for a physician facing a problem like that posed in the hypothetical. Perhaps this is because there are no clear answers. Since so little is known about the disease itself, it is very difficult to propose effective legislation pertaining to it. Still, the medical profession has been placed in an intolerable situation. Doctors are instructed to counsel and encourage seropositive individuals to discuss their condition with their sexual partners. If this request is refused and those at risk

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patient's contacts will be informed that they have been exposed to the infection, but will not be told the source of the exposure. This is problematic, if not ridiculous. If the third person has been married and faithful for many years, he or she will know the source of the exposure despite any feeble attempts at confidentiality.

120. *Id.* at 21.

are known to the doctor, "good medical practice"<sup>121</sup> obligates the doctor to inform them. Is the doctor who does so then subject to liability for breach of confidentiality? The traditional view of the American Medical Association rejects this notion since disclosure is "necessary in order to protect the welfare of the . . . community."<sup>122</sup> But section 4-301 of Maryland Health-General Code Annotated is more strict. Unless the doctor's conduct is authorized by one of the enumerated exceptions, disclosure of the information is prohibited. Doctors should not be forced to make such a choice. The American Medical Association agrees and has proposed the following recommendations:

Specific statutes must be drafted which, while protecting to the greatest extent possible the confidentiality of patient information, (a) provide a method for warning unsuspecting sexual partners, (b) protect physicians from liability for failure to warn the unsuspecting third party but, (c) establish clear standards for when a physician should inform the public health authorities, and (d) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.<sup>123</sup>

These proposals are easy to suggest but difficult to effectuate.<sup>124</sup>

At the very least, the American Medical Association Council on Ethical and Judicial Affairs' recommendation to enact legislation protecting "physicians from liability for failure to warn the unsus-

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121. *Id.*

122. *See supra* note 75 and accompanying text.

123. *See Council Report, supra* note 44, at 3.

124. The Council on Ethical and Judicial Affairs recommends providing a method for warning unsuspecting sexual partners. It appears that this could be accomplished in a number of ways. The seropositive individual could tell his or her partners, the doctor could do so, or the burden could be placed on the Health Department. Initially, it seems that the most practical and efficient way to warn people would be to do so through the Health Department. If HIV-positive individuals were reported to the Department of Health and Mental Hygiene, the agency could warn sexual contacts in much the same way that it does with other communicable diseases. The Secretary has the authority to make reporting mandatory and the mechanism for contact tracing is already in place. This method would relieve physicians of the burden and place it with an agency already equipped to handle it. Furthermore, tracing through the Health Department serves to protect the doctor-patient relationship as it distances the doctor from the actual disclosure to the contacts. The integrity of the profession is thereby preserved as doctors will be able to concentrate on treatment and care instead of patient investigation.

There are a number of factors, however, which weigh heavily against mandatory reporting of seropositive individuals. *See supra* notes 97-110 and accompanying text. Perhaps most important is the fact that reporting will discourage people from being tested. This, alone, may be sufficient to warrant abandoning the idea of mandatory reporting.

pecting third party"<sup>125</sup> should be implemented. Such legislation would be in harmony with the disclosure prohibition of section 4-301,<sup>126</sup> and would remove the physician from the situation of potential liability to suit regardless of his or her conduct. Unfortunately, this provision alone does nothing to protect the innocent third party. It is only if the Council's complete recommendation is adopted that all interests involved (those of the individual, his or her contacts, society, and the physician) will be addressed.

Currently, Maryland law provides insufficient guidance for doctors forced to chose between honoring the traditional doctor-patient confidentiality and warning unsuspecting third-parties of substantial foreseeable harm. Until some definite legislation is passed, the doctor's position is a perilous one.

JUDITH C. ENSOR

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125. See *Council Report*, *supra* note 44, at 3.

126. MD. HEALTH-GEN. CODE ANN. § 4-301 (1987).